

## Indiana Family & Recovery Works Social Services Administration Division of Mental Health and Addiction Prior Authorization Form



Name of Designated Agency:					Date (month/day/year)	
Name of Designated Provider:				Unique identification number of participant:		
Type of Prior Authorization:						
	PA Service		Participant Cap Increase		Special Request	
Prior Authorization Services:						
	Inpatient Detoxification					
	Medication Assisted Treatment (OTP Bundle) Monthly PA					
	Medication Exc	Medication Exceeding \$500 Maximum				
	Other					
<ul> <li>Please provide a narrative about this participant. Ensure that you address the following questions:</li> <li>What distinctive characteristics make this participant a good candidate for the recommended services?</li> <li>What resources have you already utilized to assist the participant?</li> <li>What plan is in place to address the participant's recovery needs in the future? (if asking for additional resources)</li> <li>How will action on this affect the participant's recovery?</li> <li>What plan is in place to get the participant Insurance Coverage, either public or private?</li> </ul>						
Narrative:						
FOR OFFICE USE ONLY						
	Approved		Rejected	Date Rv'd:		
Approved by:						
Amount or Services Approved:						
Determination Date:						